

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034642

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

317

Primary Registration District No.

547

Registrar's No.

2660

STATE FILE NUMBER

VS 300
Rev. 4/59

14005

24000

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9/99.2

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND HEIGHTS</u>		c. CITY OR TOWN <u>MEHLVILLE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARYS HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>5010 LEMAY FERRY RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JULIA MAE SKINNELL</u>		4. DATE OF DEATH Month Day Year <u>AUG - 20 - 1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1 - 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>WORTH, W. VIRGINIA</u>
13a. FATHER'S NAME <u>CHARLES FORBES</u>		13b. MOTHER'S MAIDEN NAME <u>FANNIE HACKWORTH</u>	14. NAME OF HUSBAND OR WIFE <u>LAWRENCE SKINNELL</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NIL</u>		16. SOCIAL SECURITY NO. <u>14134 FOSTER RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, acute (Kidney shut down)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Postoperative shock</u>		<u>72 hrs.</u>	
DUE TO (c) <u>Carcinoma of colon & right ovary</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Aug. 7</u> to <u>Aug. 20</u> and last saw her alive on <u>Aug. 20, 1963</u> Death occurred at <u>8:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James Thompson, M.D.</u>		22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>8/22/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG-23-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM</u>	23d. LOCATION (City, town, or county) (State) <u>CLIFF BKS MO</u>
24. FUNERAL DIRECTOR <u>FAY FUNERAL HOME, MEHLVILLE MO</u>		25. DATE RECD. BY LOCAL REG. <u>8-22-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Hubert J. Gou Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.